



Case Management

Policy & Reimbursement

Revised 10/10/19

Where is BH Case Management Policy?

- Part 21 Outpatient Behavioral Health Services
- Oklahoma Health Care Authority
www.okhca.org
- Behavioral Health Services page
- Rules
 - Part 21 Outpatient Behavioral Health Services
 - 317:30-5-241.6. Behavioral Health Case Management

What is Case Management?

The Big IX

1. Needs Assessment - necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

2. Service Plan Development – Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care (service/treatment plan).

The Big IX

3. Referral - When an individual/family is in need of specific resource information (such as a name, phone number and/or address) and can **take the information and make the linkage and advocate for themselves.**

4. Linkage - When an individual/family is in need of specific resource information, and **needs assistance with linking up** with that resource.

The Big IX

5. **Advocacy** - When an individual/family is **unable to successfully express their needs and interests** and needs assistance with communication to access a specific resource.

6. **Follow-up** - Follow up with the individual and/or family to **help the stay engaged in treatment**.

7. **Monitoring/Support** - monitoring and support **related to the individual CM plan of care-** assessing progress and barriers, and reassessing goals/objectives.

The Big IX

8. **Outreach** –Outreach with the individual and/or family to help the **stay engaged in treatment**, appointments.

9. **Crisis Diversion** - (**unanticipated, unscheduled**) situation requiring supportive assistance, **face-to-face or telephone**, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) **to assist member(s) from progression to a higher level of care.**

(3) Excluded Services.

SoonerCare Reimbursable behavioral health case management does not include the following activities:

- (A) physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment; or
- (B) managing finances; or
- (C) providing specific services such as shopping or paying bills; or
- (D) Delivering bus tickets, food stamps, money, etc.; or

Excluded Services.....

- (E) counseling, rehabilitative services, psychiatric assessment, or discharge planning; or
- (F) filling out forms, applications, etc., on behalf of the member **when the member is not present**; or
- (G) filling out SoonerCare forms, applications, etc.;
- (H) mentoring or tutoring;
- (I) provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;

Excluded Services...

- (J) non-face-to-face time spent preparing the assessment document and the service plan paperwork;
- (K) monitoring financial goals;
- (L) services to nursing home residents;
- (M) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or
- (N) services to members residing in ICF/IID facilities.

(4) Excluded individuals.

The following SoonerCare members are not eligible for behavioral health case management services:

- (A) children/families for whom behavioral health case management services are **available through OKDHS/OJA staff without special arrangements** with OKDHS, OJA, and OHCA;
- (B) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;
- (C) residents of ICF/IID and nursing facilities unless transitioning into the community;
- (D) members receiving services under a Home and Community Based services (HCBS) waiver program.

Procedure Code & Limit

		Modifier		Age	Calendar limit (Per rolling 12 months)	Contract Type
Targeted Case Management LBHP/MA level	T1017	HE/HF	HO	0-999	16	110 - OPBH
Targeted Case Management CMII MA/BA level	T1017	HE/HF	HN	0-999	16	110 - OPBH
Targeted Case Management CMI BA/less than BA level	T1017	HE/HF	HM	0-999		110 - OPBH

Effective 11/1/2019

- As of 11/1/2019 regular outpatient clients are restricted to 12 units per month (rolling year) of ***behavioral health case management (T1017)***, unless the client meets the medical necessity criteria (MNC)

Medical Necessity Criteria

- Client has been **admitted to behavioral health inpatient, crisis unit, mobile crisis or urgent care in the last five years**. The ending date for eligibility is five years after the last discharge. A report in PICIS will be available by 9/8/2017 to identify those individuals which meet this eligibility requirement.
- Any consumer of any age with an **Substance Use Disorder** service focus listed **on their CDC**
- **Adults (18+)** who are either: (a) enrolled at a certified substance abuse agency and have a substance abuse service focus on the CDC or (b) enrolled in a specialty court program. Eligibility is only maintained while enrolled in those programs.
- **Client is currently homeless**, as identified on the CDC as 'Homeless-Shelter' or 'Homeless-Streets'. The Medical Necessity Criteria only applies if currently homeless.
- Note: If the client meets any of these criteria, but is not identified in the PICIS or MMIS system as such, **providers need to submit a PA Adjustment with supporting documentation**.

Billing Details

- If the client meets any of the medical necessity criteria provided above, providers will need to include a '**GD**' modifier on the case management claim at the end of the current service.
- For example,
T1017 HEHM change to **T1017HEHMGD**.
- **Note:** If provider bills a claim with a 'GD' modifier and it is later determined that the client did **NOT** meet criteria, If not corrected within 30 days of payment, claim will be recouped.

BE ADVISED

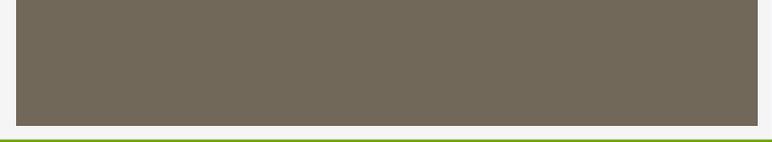
- This is specifically for CASE MANAGEMENT services. Any customer follow up, engagement or rehab services are billed on a separate code that will not count against their units.
- Do not assume your client will not meet criteria for their units to be adjusted. Do not let your agency assume.
- PACT, SOC/WRAPAROUND, AND HEALTH HOME clients are not effected by these changes at all.

How to continue to help your clients within these new changes

- Be sure to differentiate correctly what is Rehab and what is Case Management and teach them skills to could elicit themselves being their own advocate and resource guide
- If certified as a Peer Specialist or Wellness Coach, you can supplement some appropriate and billable sessions through those billing codes

Helpful Links

- www.odmhsas.org/arc.htm
- <http://www.okhca.org/providers.aspx?id=100>



OHCA



Claims

1-800-522-0114

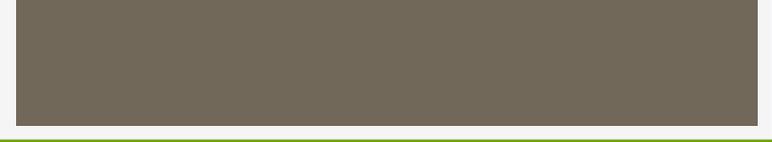


Policy

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Questions?